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Social Support and the Effectiveness of Group Therapy

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Collected self-report data from 37 pretest clients and 26 of the same clients at posttest who participated in six counseling center therapy groups. Questionnaires assessed six functionally different types of social support provided from two sources, therapy group members vs. persons outside the group, together with pre- and posttest levels of three distress symptoms, which were depression, self-esteem, and psychological symptoms of stress. Significant improvement in symptoms was noted during the eight-week interventions, and this improvement was related to the availability of social support, depending on the type and source of support. In general, support from sources outside the therapy group appeared to have the most impact. Levels of certain types of support differed in groups depending on whether or not the group was composed of members with a common presenting concern.

Social support is an important coping resource for persons experiencing stressful life changes (see Cohen & Wills, 1985; Leavy, 1983, for reviews). Mutually exchanged social support is also an important aspect of theme-oriented therapy groups that bring together persons who have experienced the same trauma, life transition, or other presenting problem, for example, victims of incest (Hall, Kassees, & Hoffman, 1986), military veterans (Gressard, 1986), or persons coping with bereavement (R. Schwab, 1986). In addition, social support has been identified as contributing to the effectiveness of general process therapy groups composed of members with a wide variety of presenting concerns (Yalom, 1985). However, little is known about how social support specifically benefits members of either type of group.

Studies of social support in nontherapeutic contexts have typically found a modest relation between perceived support and lower levels of stress symptoms, but recent writers have criticized many of these studies for assessing social support with one omnibus measure and measuring stress with a single index of accumulated life changes (cf. Thoits, 1985). Advocates of the specificity hypothesis contend that social support is multidimensional and functions in a stressor-specific manner. Different types of support provide different coping resources, and because stressors vary in adaptational demands, a given type of support will be effective only when the coping resources it provides are matched to the demands of the stressor (Cohen & Wills, 1985; Wilcox & Vernberg, 1985). Unidimensional indicators of support fail to capture this complexity.

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Evidence supporting the specificity hypothesis has accumulated from studies that used multidimensional measures of social support. For example, Cutrona and Russell (1987) developed a six-factor measure of social support based on a model of social provisions, which are forms of emotional or tangible assistance obtained from relationships with others. This model was originally conceived by Weiss (1974) as a theory of loneliness. Subsequent studies have found that not only does the perceived lack of a particular type of support (social provision) lead to differences in subjective feelings of loneliness as Weiss predicted (Russell, Cutrona, Rose, & Yurko, 1984) but types of support also appear to differ in usefulness as coping resources depending on the particular stressor. For example, reassurance of worth support provides affirming feedback about competence and abilities and was most closely related to older workers' successful coping with job loss (Mallinckrodt & Fretz, 1988) and to preventing burnout among nurses (Constable & Russell, 1986) and classroom teachers (Russell, Altmaier, & Van Velzen, 1987). However, this form of support was not as helpful to first-time mothers as was guidance support, which involves the availability of a confidant who may provide authoritative advice (Cutrona, 1984). Reliable alliance support, the perception that someone can always be counted on to provide assistance in an emergency, was crucial for elderly persons living in rural areas (Chwalisz, Russell, Cutrona, & Mallinckrodt, 1988).

Research has also suggested that social support varies in effectiveness depending on its source (Gottlieb, 1978; Wilcox & Birkel, 1983). For example, support from co-workers or supervisors was found to moderate the effects of occupational stress, but support from spouses or friends outside the work setting was much less effective (La Rocco & Jones, 1978). These findings are relevant in considering sources of social support available to members of therapy groups, who exchange mutual support but, particularly in general process groups, are also encouraged to gain interpersonal skills to help them mobilize support from sources outside the group (Yalom, 1985). In fact, the most important long term therapeutic gains may be related to increased support from these sources in the natural social environment (Brown, Brady, Lent, Wol-

fert, & Hall, 1987; Rook, 1984). Conversely, for members of theme groups who have experienced the same life stresses, mutually exchanged support may be more effective than the same type of support provided by persons outside the group who have not experienced the stressor.

Information about which types and sources of social support are most beneficial to therapy group members may help to increase therapeutic effectiveness of the groups, but no previous study that investigated these factors could be located. Thus, the purpose of this study was to identify the specific source of support, group members versus sources outside the group, and specific types of support that are most closely associated with positive changes in psychological symptoms of stress, including depression, self-esteem, and global psychological symptoms. In addition, because support processes may differ depending on the nature of the therapy group, this study examined differences in support for members of theme-oriented and general process therapy groups.

Method

Participants and Procedure

Clients assigned to group therapy at a university counseling center located in the Rocky Mountain states participated in the study. Their cooperation was solicited by group leaders during the first therapy session. Pretest materials were distributed by group leaders with a request to complete the packets at home and return them to the counseling center receptionist before the next group meeting. Clients were assured that their decision about participation would not affect the counseling services they received and that group leaders and the researcher would remain unaware of which clients chose not to participate. Of 48 clients who were members of the six therapy groups run during the data collection period, 37 (77%) chose to complete pretest materials.

Of the original 48 clients, 38 (79%) continued in therapy until their groups were terminated. During the last session of each group, posttest materials were distributed with a request to return materials by mail in prestamped envelopes. Clients labeled materials for both pre- and posttest packets only with their mothers' maiden names. In this way anonymity was maintained while allowing the matching of pre- and posttest data. Unfortunately, this procedure made it impossible to identify clients who did not complete the posttest packets after the initial distribution and to mail follow-up materials.

Of the original 37 clients who completed pretests, 26 (70%) chose to return posttests. Procedures used to assure anonymity made it impossible to determine how many of the 11 clients who did not complete posttest materials were, in fact, among the 10 clients no longer in therapy at posttest. For the 26 pre–post clients, the mean interval between completion dates of the pretest and posttest materials was 7.8 weeks. Clients in theme groups comprised 62% of the pretest participants (23 from a total of 37) and 62% of the pre–post participants (16 from a total of 26). Pre–post participants included 18 (69%) women and 8 (31%) men. Their mean age was 24.9 years ($SD = 5.5$). Two clients reported a Hispanic ethnic identification, and the remaining 24 (92%) indicated that they were White.

Therapy Groups

To sample the widest possible range, all six therapy groups offered by the counseling center during the semester of data collection were included in the study. All were closed membership, time-limited, semester-length interventions that met once per week for approximately 90 min. None of the groups were structured interventions, although some theme groups involved occasional didactic instruction. All groups were led by two cofacilitators (two female–female pairs, one male–male pair, and three female–male pairs). Three persons led two different groups. Of the nine counselors who served as coleaders, two were senior staff members, two were interns, and five were advanced graduate students. Four of the six groups were theme oriented; that is, clients were assigned on the basis of a cluster of similar presenting concerns. In one group the clients were nontraditional-age students; in another the clients had experienced the ending of a romantic relationship; another was a women's support group; and the fourth was an eating-disorders group for women. The remaining two were general process groups in which clients had a variety of concerns.

Measures

At both pre- and posttest the participants completed a measure of perceived social support and three symptom measures of self-esteem, depression, and psychological symptoms of stress. These particular symptoms were selected because they represented a broad range of potential client changes in the diverse groups studied.

Social support. The Social Provisions Scale (SPS; Cutrona & Russell, 1987; Russell & Cutrona, 1984) is a 24-item measure of perceived social support. Clients respond on a 4-point Likert scale (1 = *strongly disagree* to 4 = *strongly agree*). Six subscales, composed of four items each, are used to assess different social support provisions. Labels for the six types of support, the functional psychological needs each is believed to satisfy, and representative items from the SPS subscale are: (a) *attachment*, feelings of safety and security in a close emotional bond, "I lack a feeling of intimacy with another person"; (b) *social integration*, interests and concerns are shared by others, "I feel a part of a group of people who share my attitudes and beliefs"; (c) *reassurance of worth*, having skills and abilities acknowledged, "there are people who admire my talents and abilities"; (d) *reliable alliance*, assurance that one can count on assistance being available if needed, "there are people I can count on in an emergency"; (e) *guidance*, availability of confidants or authoritative others to provide advice, "there is no one I feel comfortable talking about problems with"; and, (f) *opportunity for nurturance*, the sense of being needed in vital ways by other persons, "there is no one who really relies on me for their well-being."

Russell and Cutrona (1984) reported internal consistency (coefficient alpha) for each of the subscales ranging from .76 to .84 in a sample of older adults and from .61 to .76 in a sample of teachers. They reported test–retest reliabilities ranging from .37 to .66 for the subscales and a total scale test–retest reliability of .59. A confirmatory factor analysis resulted in a goodness-of-fit index of .86 for the subscales, which indicates a fairly good fit of the data to Russell and Cutrona's six-factor model.

At pretest the clients in this study were instructed to consider "all current relationships" in completing the SPS. At posttest clients completed one copy to assess their perceptions of support only from group members and a second copy to assess support from "all current relationships excluding group leaders and group members."

Self-esteem. The Rosenberg Self-Esteem Scale (Rosenberg, 1965) consists of 10 items scored on a 4-point Likert scale (1 = *strongly disagree* to 4 = *strongly agree*). Internal consistency (coefficient alpha) of .81 has been reported (Mallinckrodt & Fretz, 1988). A test–retest reliability of .85 was obtained after a 2-week interval (Silber & Tippett, 1965), and the scale correlated well with other measures of self-esteem and with clinical assessments (correlations ranging from .56 to .83).

Depression. The Beck Depression Inventory (BDI) is a widely used self-report measure of depression consisting of 21 items, each item containing four self-report statements representing a cluster of symptoms (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The statements reflect different cognitive–bahavioral levels of depression and are scored on a 0–3 scale, with higher scores indicating more depression.

Psychological symptoms. The Bell Global Psychopathology Scale (BGPS; J. J. Schwab, Bell, Warheit, & Schwab, 1979) consists of 33 self-report items yielding eight subscale scores of psychological symptoms of stress (e.g., depression, anxiety, obsessive thoughts, phobias, and hallucinations). Although J. J. Schwab et al. analyzed each of the BGPS subscales individually, in order to limit the number of analyses in this study, only the total BGPS score was used as a global indicator of psychological distress. Participants respond considering their "experience of the past month or so" using 5-point (1 = *never* to 5 = *all the time*) or 2-point scales (1 = *no* or 2 = *yes*). The BGPS has demonstrated internal consistency (coefficient alpha) and test–retest reliability correlations all greater than .80, and the total BGPS score was significantly correlated ($r = .74$) with a widely used measure of psychopathology, the Health Opinion Survey (J. J. Schwab et al., 1979).

Results

A one-way multivariate analysis of variance (MANOVA) was used to compare the 26 pre–post clients and the 11 pretest only clients regarding pretest levels of each of the research variables. No significant differences were found, $F(1, 35) = 2.05$, $p > .05$. Consequently, all 37 clients were included in pretests analyses as the most representative sample for determining the relation of social support to symptom variables at the point clients begin therapy. Table 1 presents a correlation matrix of the relations among the six types of support and three symptom variables. Results indicated that different types of support varied in the magnitude of their negative relation to symptom levels and that reliable alliance, attachment, and reassurance of worth seemed to exhibit the highest negative correlations with symptom measures.

A one-way, repeated measures MANOVA was used to compare pre- and posttest levels of symptoms and social support from sources outside the group for the 26 pre–post clients. Significant overall pre–post differences were obtained, $F(8, 18) = 304.7$, $p < .001$. The results of repeated measures t tests used as univariate follow-ups are shown in Table 2. During the course of therapy clients exhibited significant gains in total support and several specific types of support from sources outside the group. There were also significant improvements in clients' self-esteem, depression, and BGPS scores.

The effects of support from different sources, group members versus persons outside the group, are compared in Table 3. Changes in symptoms are represented by partial correlations of support with posttest symptoms, controlling for pretest symptom levels. In general, support from outside sources appeared to be more closely associated with positive changes in symptoms than support from group members. For example, total support from persons outside the group was related to improvement in self-esteem (partial $r = .64$, $p < .01$) and to decreased levels of depression (partial $r = -.48$, $p < .01$), whereas total support from group members was not (partial $rs = .11$ and $.17$, respectively). An unexpected finding was that opportunity for nurturance support from other group members was positively correlated with depression.

Finally, a one-way MANOVA was used to compare members of theme groups with members of general process groups regarding support from group members and from sources outside the group. The analysis indicated significant overall differences, $F(6, 19) = 6.14$, $p < .001$. Univariate follow-ups indicated no differences in support from outside sources, but two types of support from other group members were more available to clients in theme groups, guidance support, $F(1, 24) = 10.67$, $p < .01$, and reliable alliance support, $F(1, 24) = 8.57$, $p < .01$, with a trend toward more available attachment support, $F(1, 24) = 3.91$, $p < .06$. Tests of demographic differences indicated that there was no difference in gender distribution between the two types of groups, but members of theme groups were significantly older ($M = 26.6$ years, $SD =$

Table 1
Pretest Social Support and Symptom Intercorrelations

Variable	1	2	3	4	5	6	7	8	9	10
Social support										
1. Total support	—	.88	.90	.89	.70	.71	.67	−.23	−.74	.69
2. Reliable alliance		—	.81	.73	.52	.61	.51	−.22	−.68	.57
3. Attachment			—	.77	.66	.48	.48	−.29	−.77	.73
4. Guidance				—	.76	.49	.43	−.14	−.57	.56
5. Opportunity for nurturance					—	.18	.16	−.08	−.37	.30
6. Social interaction						—	.72	−.15	−.58	.43
7. Reassurance of worth							—	−.20	−.57	.64
Symptoms										
8. BGPS								—	.46	−.47
9. Depression									—	−.81
10. Self-esteem[a]										—
M	72.8	13.3	11.4	13.2	10.2	12.7	12.1	44.2	14.9	27.7
SD	11.3	1.9	3.3	2.5	2.2	2.1	2.1	16.7	9.5	6.2

Note. $n = 37$. BGPS = Bell Global Psychopathology Scale. For correlations greater in absolute value than .28, $p < .05$; for correlations greater in absolute value than .42, $p < .01$.
[a] Higher scores indicate more positive self-esteem.

Table 2
Pretest to Posttest Changes in Symptoms and Support

Variable	Pretest *M*	Pretest *SD*	Posttest *M*	Posttest *SD*	t^a
Symptoms					
Self-esteem[b]	27.4	6.5	29.2	7.0	2.78**
Depression	16.0	9.7	12.5	7.2	2.30*
BGPS	43.3	12.0	37.2	9.4	2.61*
Social support from sources outside the group					
Reliable alliance	13.2	1.7	13.8	1.8	1.93†
Attachment	10.9	3.3	12.1	3.4	4.95**
Guidance	12.8	2.5	13.3	2.8	1.73
Opportunity for nurturance	9.5	2.1	10.3	2.2	2.30*
Social integration	12.8	1.9	13.3	1.5	1.86
Reassurance of worth	12.1	2.3	12.7	2.0	2.42*
Total social support	71.4	11.0	75.5	11.4	4.10**

Note. $n = 26$. BGPS = Bell Global Psychopathology Scale.
[a] $df = 25$, repeated measures t tests. [b] Higher scores indicate more positive self-esteem.
* $p < .05$. ** $p < .01$.
† $p < .07$.

6.2) than general process groups ($M = 22.2$ years, $SD = 2.8$), $t(24) = 2.11$, $p < .05$.

Discussion

Results of this study provide support for some elements of the specificity hypothesis. Ten of the 15 correlations among the six types of support were less than .70 at pretest, which suggests a multidimensional structure for the social support construct. At pretest different types of support also varied in their relation to different symptoms, which suggests that each provides somewhat different coping resources.

Furthermore, pre–post comparisons indicated significant improvements in all three symptom measures for therapy group participants, although these changes cannot be unambiguously attributed to effects of the therapy, because there was no untreated waiting-list group of clients available for comparison. Interestingly, support from persons outside the groups also improved significantly from pretest to posttest. Most notably, attachment support (close emotional bonding) increased, and it was the lack of this support that was most closely associated with depression and low self-esteem at pretest. Perhaps a significant proportion of the improvement in symptoms was due to gains in beneficial support from sources outside the group. If so, this finding would support the therapeutic strategy of helping clients to acquire interpersonal skills for mobilizing support in their natural social environment (Brown et al., 1987; Rook, 1984).

The primary purpose of this study was to identify the sources and types of social support most closely related to positive changes in specific stress symptoms. In general, it appears that social support from persons outside the therapy group may be more beneficial than support from other group members. Of the 18 correlations between the six types of outside support and the three symptoms measures, 10 were significant, whereas only three of the 18 correlations for group member support were significant, and opportunity for nurturance support from group members was positively correlated with depression (see Table 3).

Thus, these findings suggest different effects for specific types of support depending on the source. For example, attachment support (close emotional bonding) and reliable alliance (others can be counted on for help in an emergency) may be related to improvement in self-esteem and depression but only if this support is provided through relationships with persons outside the therapy group. However, reassurance of worth support (affirmation of competencies and abilities) seems to have a beneficial effect on self-esteem if provided by either source. Only one support–symptom relation showed a stronger negative correlation for group sources than for outside sources, namely reliable alliance and BGPS scores. Among the symptoms measured by the BGPS are anxiety, phobias, and obsessive thoughts. Perhaps the perception that group members can be counted on to provide help in an emergency may be more effective in reducing these symptoms because clients believe that other group members are more able (compared with those outside the group) to understand their anxieties and help them cope with potential crises.

It is difficult to explain the finding that opportunity for nurturance support from group members was positively correlated with depression. Cutrona and Russell (1987) pointed out that "strictly speaking, this [opportunity for nurturance] cannot be considered social support, in that the individual is the provider rather than the recipient of assistance. However, . . . giving and receiving help may enhance health through

Table 3
Correlations of Support From Therapy Group Members (Group) and From Relationships Outside the Group (Outside) with Change in Symptoms

Type of support and source	Self-esteem[a]	Depression	BGPS
Total support			
Group	.11	.17	−.32
Outside	.64**	−.48**	−.26
Reliable alliance			
Group	−.04	.23	−.57**
Outside	.53**	−.36*	−.33
Attachment			
Group	.02	.19	−.25
Outside	.60**	−.39*	−.16
Guidance			
Group	−.13	−.14	−.29
Outside	.52**	−.44*	−.31
Opportunity for nurturance			
Group	−.27	.38*	.10
Outside	−.20	−.23	−.07
Social integration			
Group	.57**	−.10	−.01
Outside	.61**	−.10	−.50**
Reassurance of worth			
Group	.67**	.07	−.31
Outside	.80**	−.66**	−.16

Note. $n = 26$. BGPS = Bell Global Psychopathology Scale. Partial correlations are of social support with posttest symptoms, controlling for level of symptoms at pretest.
[a] Higher scores indicate more positive self-esteem.
* $p < .05$. ** $p < .01$.

some of the same cognitive mechanisms" (p. 42). Research suggests that the opportunity to nurture others does indeed furnish the provider of this assistance with the same types of psychological coping benefits as other, more direct, forms of social support (Mallinckrodt & Fretz, 1988). However, in this study depression was correlated with increased perceptions by clients that other group members were dependent on them for their sense of well-being. Perhaps some clients perceived the dependency needs of some other group members as overwhelming. Some clients, especially women, may also invest increased efforts in nurturing others while their own psychological well-being suffers (Gilligan, 1982; Norwood, 1985). In any case, this finding suggests that not all types of support from group members may be beneficial.

The final purpose of this study was to compare support perceived by members of theme-oriented and general process therapy groups. The results suggest that clients in both types of groups had equivalent perceptions of support from sources outside the group. However, regarding support from group members, participants in theme groups apparently perceived greater availability of guidance support (available confidants or authoritative advice) and reliable alliance support (others can be counted to help in an emergency), with a trend toward greater attachment support.

Guidance and reliable alliance support often involve direct offers of advice or help. Research has shown that such offers, no matter how well intentioned, may sometimes have a negative impact on persons experiencing a traumatic life event, especially if the offer is unsolicited and made by persons who have not experienced a similar trauma (Lehman, Ellard, & Wortman, 1986). However, direct advice and other forms of tangible assistance may be welcomed and sought from persons who have experienced the same stressor, even though individuals vary greatly in their ability to actually profit from this assistance (Gottlieb, 1983). Relative to members of general process groups, perhaps because of assumed shared experiences, members of theme groups may have felt a greater willingness to confide and accept direct advice from one another, or they may have perceived more helpful potential emergency assistance.

The trend toward higher levels of attachment support (a sense of close emotional bonds) between members of theme groups may reflect what Parson (1985) terms "post-traumatic accelerated cohesion," the rapid and premature development of cohesion in groups of persons who have experienced the same traumatic event. Parson believes this premature cohesion is often countertherapeutic because it is based only on superficial characteristics of group members. This early sense of "we-ness" tends to delay the healthy exploration of conflict and anxiety and may interfere with the development bonds based on deeper aspects of personality. Whatever the therapeutic effects, the trend observed in this study suggests that members of theme groups may have perceived a closer attachment bond with one another than members of general process groups.

Differences in theme versus process groups may have also been due to the occasional didactic instruction given in theme groups, although in rating support within the groups, clients were instructed to exclude support from group leaders. A further complicating factor may have been contacts between group members that occurred outside the group sessions. Leaders of general process groups warned clients against such contacts, whereas leaders of theme groups were mixed in whether or not they gave such a warning. In several instances outside contacts were known to have occurred between members of theme groups.

Findings of this study must be interpreted cautiously and regarded only as a pilot exploration of social support in therapy groups because several factors may limit the generalizability of results. In studying actual clients in therapy, compromises in design were required to ensure the quality of clients' therapeutic experience, to protect clients from undue pressure to participate in this study, and to maintain client anonymity. For example, multiwave survey mailings and vigorous follow-up tracking procedures to achieve higher return rates were not possible. Consequently, only 77% of the clients chose to participate initially, and only 70% of these completed posttest materials. Although a 20% attrition rate is considered typical for many therapy groups, the subsample in this study who completed pre- and posttest materials may have been different from other clients in important respects. Moreover, the final sample size of 26 is small and further limits generalizability.

In analyses comparing general process groups to theme groups data from very different theme groups were combined. This was a practical necessity because individual groups contained as few as 3–4 participating clients. Thus, in testing the specificity hypothesis, only the requirement to use a multidimensional measure of support was met. The requirement of assessing specific stressors must await studies conducted over several years to accumulate a larger number of participants in the same theme group. These problems notwithstanding, finding differences in social support from group members when comparing very diverse combinations of theme and general process groups suggests a robust phenomenon that needs further exploration.

The findings of this study, if replicated in future research, do suggest that both the source of social support, type of social support, and type of support group all may have important implications for therapeutic change. Not every type of support from every source may be beneficial. Further empirical investigation of group member support processes may suggest ways facilitators can maximize the availability of the most helpful types of social support.

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